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## CLINICAL LECTURE.

### THE INFLUENZA.—INFLUENZA WITH SLOW INCUBATION, AS COMPLICATION OF NEPHRITIS.—INFLUENZA WITHOUT ELEVATION OF TEMPERATURE.—DIFFERENTIAL DIAGNOSIS OF INFLUENZA.—DANGEROUS COMPLICATIONS.<sup>1</sup>

BY J. M. ANDERS, M. D.

### The Influenza, with Sudden Onset.

Gentlemen: I propose to-day to devote the hour to the consideration of a disease which is at present prevalent in so many and in such widely separated localities, and which is variously known as "la grippe," influenza and epidemic catarrh. I shall not, for want of time, go into a full historical

sketch of it. Suffice it to state that our earliest authentic knowledge of it dates back to the beginning of the sixteenth century. It is true that it was mentioned by Hippocrates, but his description was lacking in precision. In the winter of 1847-8 there was a severe epidemic of influenza in this and other countries, and its mortality in London reached as high as two per cent.

Among the predisposing causes of the disease may be mentioned general poor health. I call this a predisposing cause. Perhaps it would be better to say that, although persons of all grades of health are attacked alike by it, the ones that are weak and delicate are the more seriously affected. In the same way it has been noticed that the aged and very young have it worse than the middle-aged. It is no respecter of persons, place nor seasons, and in this way differs from ordinary colds which generally occur most frequently in bad weather and among those who are exposed or poorly nourished. The exciting cause is supposed

<sup>1</sup> Delivered at the Philadelphia Hospital.

to be a micro-organism or germ, although it has not yet been isolated, notwithstanding the many efforts that have been put forth in various parts of the world to do so, with the hope that the disease might be thereby more successfully combatted.

Another interesting and practical question is, whether this affection is contagious or not. A scientific controversy is now in progress to determine this point. My own opinion is that it is but feebly contagious. On the other hand we have the following interesting circumstance that is vouched for by Drs. White and Guitérás of the University of Pennsylvania. These gentlemen state that a man who had the disease in London and who went immediately to Paris, there became speedily worse and died. His body was embalmed and sent to this country to his home where the disease was not then prevalent. When he was brought home the coffin was opened and the remains viewed by his family. Of the persons who saw the body several soon afterwards had the catarrh, though they had not been otherwise exposed to any visible source of contagion. A total of eighteen cases appeared. If the disease be due to a specific organism, the mucous membranes of the nose, lungs and throat seem to be the favorite localities for its growth and development, and it does not seem at all unreasonable to suppose that these germs, which must be more numerous here than in the air, are given off with the expired air, and give rise to disease in those coming in contact with influenza patients. The symptoms of influenza we shall study in the case of the man who has been brought before us. His attack began about ten days ago. He had a few hours of malaise and then a chill which was immediately followed by a fever, backache and pains in the various joints of his body and limbs. This is the common mode of onset when the disease comes on suddenly. There are some authors who state that it comes quickly and goes as quickly. The former statement may or may not be true; the latter has not been my experience. The temperature chart is irregular—a sudden ascent, but not so sudden a descent to normal, and in this latter regard it differs from the temperature in intermittent fever. In a few cases it reaches a very high point. Here it went on the first day as high as  $103^{\circ}$  F. On the next day it was down to  $100^{\circ}$ , and on the third day it descended to normal. The pulse at first was full and frequent, but, as is generally

the case, when the fever began to defer-  
vesce the previously full pulse became weak  
and even thready. The skin, too, of the  
face and neck was red and dry until the  
sweating set in, and this was profuse and oc-  
curred several times during the day.

The urine is generally lessened and con-  
tains a large quantity of urates. It may be  
retained and, of course, the symptoms are  
then more serious. I have met one case  
of retention of urine in a child. He passed  
no water for twenty-four hours and it then  
flowed freely.

In this present case the catarrhal manifesta-  
tions began in the nasal mucous membrane,  
though there was not much sneezing. But the  
main seat of the catarrhal affection here was in  
the bronchial tubes where it remained for sev-  
eral days. The physical signs were almost  
negative. The cough in these cases is apt  
to be out of all proportion to the physical  
signs and to assume a paroxysmal character  
which has often been taken for whooping  
cough. There are generally a few dry  
crepitant râles. If bronchitis is developed,  
there is no dulness; but sonorous and sibil-  
ant râles which, as the disease progresses,  
become coarser and bubbling. Where there  
is no true bronchitis developed we might  
call the condition a laryngo-bronchial  
irritation, and with this state of the bron-  
chial mucous membrane we may have a gas-  
tro-intestinal irritation which is manifested  
by vomiting and a tendency to pass into  
catarrhal dysentery.

The nervous symptoms are generally diz-  
ziness, sleeplessness, a tendency to fainting,  
and sometimes habitude. The pains in the  
back and limbs may be attributed to irritation  
of the nervous system. As a rule, the  
severer pain occurs near to, rather than di-  
rectly in, the larger joints. It may also be  
situated in the muscles. It often occurs in  
the lower intercostal spaces and this is espe-  
cially apt to come on in the later stages of  
the disease.

The treatment here, as in most cases, has  
been simple. In uncomplicated cases active  
treatment is not necessary. Many patients  
would do well, if they could only be pre-  
vailed on to go to bed and keep warm, and  
to eat lightly, if the stomach shows any sign  
of irritation, and to use for their sore throat  
some simple gargle, such as one composed  
of *rhus glabrum*, potassium chlorate and car-  
bolic acid. This may be used diluted every  
few hours. The remedies that this man has  
been taking are antipyrin and quinine. This

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combination serves to lower the temperature and support the system, they being the two main indications in this disease. When, as was the case with this patient, there are from the first severe bronchial symptoms, wine or ipecac should be exhibited in combination with ammonium chloride or the solution of the acetate of ammonium, to loosen the secretions. This man having entered upon convalescence is now taking a tonic composed of bark and sulphuric acid. If he were an anaemic, iron would be added to this treatment. For the gastric symptoms he took small doses of calomel and soda.

#### Influenza with Slow Incubation Occurring as a Complication of Chronic Nephritis.

A. D., 28 years old, had been in the medical wards for a considerable time on account of kidney disease. In the former case the period of incubation was short. Here there were several days of malaise and general indisposition preceding the time when the attack suddenly became visible. There was then a sudden increase in the backache, headache and pains in the joints. Later, as in the other case, the pains about the base of the chest were developed. On the second day the temperature went up to 104° F.; on the next day it descended to 101° F., and in six or seven days it came down to normal. The fact that this man had previously a chronic disease is interesting; because men so affected have la grippe more severely than those who were in previous good health. His local manifestations were chiefly confined to the head and chest. In ten days from its onset, if the present rate of improvement continues, he will be as well as usual.

The gastric symptoms which were rather troublesome in this man's case frequently usher in an attack, and they are especially apt to be severe in children. The nasal and bronchial manifestations may occur in the same case as the gastric symptoms in the adult, as in the case before us, and when they do they are apt to alternate with each other. It seems that the disease, like underground water, seeks an outlet for itself here or there, or where the constitution of the individual is weakest. In this way a dysentery or a catarrhal condition of the kidneys or a bronchitis may be set up in persons who have a weakness at either of these points.

This case has been treated very much like the one that has just gone out. The man took at first antipyrin, quinine and a cough mixture. Now he is taking a tonic in which we are careful to have some iron, as Bright's disease is peculiarly liable to cause anemia.

#### Influenza with Chronic Bronchitis without Elevation of Temperature.

This woman is forty years old, from Ireland, and is a domestic. About one week ago she suddenly began to be affected with a naso-bronchial catarrh, general soreness and cough. But her temperature did not go up. This peculiarity is sometimes seen in persons who are old or debilitated. She, too, has been treated with antipyrin and quinine for the fever and catarrh. The cough is already improving. She had before the attack a chronic bronchitis and now she has an acute bronchitis superadded. The physical signs have been those of ordinary bronchitis. There were sonorous and sibilant, followed by moist bubbling râles, and later in the attack there was a profuse mucopurulent expectoration. The cough has been nearly constant and there were, in addition, numerous paroxysms which were strikingly like those of whooping cough. Considering her pre-existing troubles, she is fortunate in having already advanced far towards convalescence.

#### Differential Diagnosis of Influenza.

The influenza, especially when the period of incubation is long, has been mistaken for typhoid fever. But in this latter disease we have a steadily ascending temperature with its constant diurnal variations, diarrhoea, enlarged spleen and the typhoid eruption on the eighth day; whereas in la grippe we have a sudden elevation, but quickly falling and markedly irregular temperature and absence of the other three symptoms. Endemic catarrh has not the constant depressing nervous symptoms nor peculiar pain of influenza, and, besides, you should always consider which disease would be most apt to be prevalent in the locality. In ordinary bronchitis you get usually a history of the patient's having been exposed to bad weather, or to alternations of temperature and the customary physical signs which I have already enumerated in this lecture, whereas in simple influenza the condition of the mucous membrane of the lungs may be called, in the majority of cases, at least, a

laryngo-bronchial irritation rather than the customary inflammation of the mucous membrane occurring in true bronchitis.

### Dangerous Complications.

These conditions may be summed up in the expression, inflammatory states of the lungs. They are: First, catarrhal bronchitis in which there is dyspnoea, lividity of the face and extremities, and generally an increase of temperature. Here the main indication in the treatment is stimulation; but not with preparations of ammonium, except liquor ammonii acetatis, which is not a stimulating expectorant, but a diuretic. Ipecac may be used with the stimulant to assist in loosening the phlegm. Second, collapse of the lung, which is often described as congestive collapse. You may understand how a part of the lung may collapse when the bronchial tube leading to it becomes occluded and cuts off its supply of air. This may be further complicated by the occurrence of catarrhal pneumonia, a not uncommon event of serious import. Third, If lobar pneumonia occurs, it comes late, suddenly, and is ushered in by a chill, whereas catarrhal pneumonia is rather a concomitant condition, developing at any time, in the course of the attack, and has, as a rule, no initiatory chill. Fourth, An emphysema may sometimes occur and with it comes asthma. Its physical signs are most marked at the base of the lungs and behind as well as along the ventral borders.

The prognosis of simple influenza in the previously healthy is always good. It may be serious in children, old persons and those worn out with debilitating diseases. The highest mortality reached by any epidemic has been two per cent. The rate of mortality varies with the character of the epidemic and especially with the concomitant diseases. The death-rate from other diseases is increased during the prevalence of influenza, and the vitality of the common mass of humanity seems to be lowered.

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**REMEDY FOR INTOXICATION.**—Half a teaspoonful of chloride of ammonium in a goblet of water will almost immediately restore his faculties and powers of locomotion to a man who is helplessly intoxicated. A wineglassful of strong vinegar will have the same effect, and is frequently resorted to by drunken soldiers to enable them to return steadily to their barracks.

## COMMUNICATIONS.

### TREPHINING, WITH REPORT OF CASES.<sup>1</sup>

BY J. E. PENDLETON, M. D.,  
HARTFORD, KENTUCKY.

Is there any good in trephining? Recently when on my way home from the meeting of the Mississippi Valley Medical Association at Evansville, Indiana, a cultivated and intellectual member of the McDowell Medical Society asked me if I had seen any good from trephining.

The question was directed to my personal experience, and after a moment's reflection I answered that I had, but did not then have time to explain the reasons for my conviction. We all know of the doubt and arguments recorded in medical literature that have harassed the career of the trephine from the earliest times, and that many of the most eminent men of the profession have given the operation of "boring the skull," as they term it, their most unqualified condemnation.

Professor Stromeyer, speaking in regard to fractures of the internal table alone as late as the year 1849, says, "these separations remain generally undiscovered," which in his opinion is lucky for the patient, because he therefore escapes the danger of being trephined.

In the *Medical and Surgical History of the War of the Rebellion* are recorded twenty cases of this most rare form of skull fracture with but a single recovery. If Professor Stromeyer knew of a like fearful rate of mortality from this peculiar lesion, all can estimate his horror of an operation that promised so little. Hardly a single well authenticated case have I been able to find recorded in the annals of surgery where a satisfactory diagnosis of this injury was made in time for a primary operation. In a few of the recorded cases the nature of the trouble was first discovered when a disk of bone had been removed for the relief of compression supposed to be the result of hemorrhage or suppuration. In the great majority of cases, its first revelation was obtained at the autopsy.

<sup>1</sup> Read at the Twenty-ninth semi-annual Meeting of the McDowell Medical Society, at Henderson, Ky., Nov. 11, 1889.

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So far, then, as fractures of the internal table alone are concerned with the use of the trephine (much as we might disagree with the opinion of Dr. Stromeyer as to its applicability, especially when the injury has been recently sustained, until all have better methods of diagnosis than have yet been used) the rate or mortality must continue to be great.

Now that all have learned of the existence of certain micro-organisms whose introduction into wounds set up dangerous pathological processes, and have also learned the great value of cleanliness and the inestimable virtues of certain chemicals, as bactericides, we are armed for the successful invasion of precincts of the human body regarded by our predecessors with well nigh a sacred awe.

Is it any wonder that the surgeon whose experience with the trephine had been obtained in a hospital badly ventilated and reeking with deadly germs should have condemned its use?

Trephining in itself is not a dangerous operation. There has not been a record of cases in which all other factors of danger have been eliminated. This operation is always done for the relief of some injury or other pathological condition which either impairs the health or imperils the life of the patient.

Operations done for the relief of epilepsy are more nearly fair examples from which to calculate the mortality rate than any other class of cases that have been recorded. Even in these, if the epileptic seizures be due to old traumatisms of the skull with spiculae of bone or exostoses impinging upon the brain or its membranes, they should be excluded.

At a clinic in Jefferson Medical College, of Philadelphia, I witnessed an operation of this kind done before the class for the relief of a confirmed epileptic by the late Professor Gross. This, together with three others of a similar kind upon which he had operated, are recorded in his great work on Surgery. Two of them proved fatal as did also the one done in the presence of the class. In the last case a spicula of bone was found penetrating the membranes, through which opening cerebro-spinal fluid escaped freely both during and after the operation. The pressure being thus removed, the vessels at the seat of softening gave evidence of producing a fatal apoplexy.

The rate of mortality for the last several years has probably been constantly reduced in

nearly all the classes of cases for which trephining has been done. The percentage of deaths in operations for traumatic epilepsy given by Ashhurst in his *International Encyclopedia of Surgery*, published in 1884, is 10.69. For simple depressed fractures, exclusive of those attended with concomitant intra-cranial injuries, he puts down a mortality of 15.29 per cent.

It has not been my fortune to have been called to use the trephine for tumors or epilepsy. My experience with the use of this instrument has been for the most part confined to recent traumatic injuries of the head. In two of the cases I have treated exostosis of the inner table was found.

Leaving behind the large number of cases I treated during my service as surgeon in the Confederate army, and before and since the war, I shall only report the last few cases upon which I have operated.

*Case 1.* S. W. S., 28 years old, plasterer by trade, industrious, but inclined to go on an occasional spree, while returning home on horseback one night, after a day of indulgence, when near his house dismounted to log down a fence, and after crossing his horse over stooped behind him to put up the gap, when he received a kick on his forehead and lay on the ground unconscious until the next morning. He was found and carried home by his friends, and when I saw him it was supposed to have been 12 hours after the accident. He was still unconscious and breathing stertorously; his pulse was feeble and irregular. His left eyelids were swollen and his face and neck almost entirely covered with dried blood. An ugly gash extended across the left side of the forehead above the eyebrow, beneath and above which a depressed fracture could be easily detected.

After cleansing the wound thoroughly with warm water and antiseptic washes, a flap was raised, disclosing a fracture of the frontal bone more than three inches in length, extending from above the external angular process across to the middle of the forehead. The upper edge of the broken area along beneath the frontal eminence was the most deeply depressed near its outer angle. A disk of bone was removed with the trephine near the line of fracture. About an ounce of partly clotted dark blood came out through the opening made by the instrument. With considerable difficulty the depressed bone was elevated and still more blood of the same character came out after the depressed bone was ele-

vated and considerable fresh hemorrhage from the ruptured anterior branch of the middle meningeal artery. A tampon of antiseptic gauze, however, soon arrested it.

Although no anæsthetic had been used he did not show signs of pain till after the depression of the bone and compression caused by the effused blood had been relieved. The flap was restored and the wound dressed antiseptically with drainage. He finally made a good recovery and was working at his trade eight months after the injury.

*Case 2.* Joseph B., 11 years old, was kicked on the left side of the forehead by a mule, was knocked down, and lay insensible on the ground, from whence he was carried home. On the way he partially aroused, vomited, and had two convulsions, and a third after he was laid on the bed at home. I saw him in consultation with Dr. J. S. Morton about four hours after the accident. He was then in a state of deep coma, totally unconscious, with a feeble, irregular pulse, and breathing with difficulty. Above the left eyebrow and extending on to the temple was a bruised and lacerated wound beneath which a fracture of the skull with depression was easily diagnosticated. His state of insensibility was so complete that we did not deem artificial anæsthesia necessary.

After perfectly cleansing the wound and the face, a flap was lifted exposing the seat of the fracture. The depth and extent of the depression was not so great as it appeared before exposing it to view. A disk of bone was cut out with the trephine one inch above and behind the external angular process, when a very considerable quantity of thick, dark blood poured out the opening, and still more came away when the depressed bone was lifted into place. The breathing and other symptoms soon began to improve. The wound was dressed, drainage effected, and treated with antiseptic care. He had for three days a temperature of  $102\frac{1}{2}^{\circ}$ , which gradually went down, and from that on his progress toward recovery was uninterrupted. He lives at Hartford, Kentucky, where he is going to school. He says he does not experience any inconvenience as an effect of the injury, except that he would like to get rid of the ugly scar made by the animal's shoe.

*Case 3.* Isaac M. B., 52 years old, farmer, while working on the road got into a dispute and was struck on the head by a "pick-axe," thrown some ten feet violently

by his assailant. He was knocked down and remained for several minutes unconscious. When he had revived a little he began to vomit, became cold and almost pulseless. In this condition he was carried to his home on a batten a half-mile away by the road hands. I saw him with Drs. Sanders and Miller three hours later. The history given was that he was "at himself" and spoke to his family intelligently about the affair when first brought in and continued to talk for half an hour or more. He then began to grow stupid and to breathe, as they said, as though he was deeply under the influence of morphine. In this condition I found him when I reached the house. The pupil of his left eye was widely dilated and the right contracted. The lid of the left eye was swollen and ecchymosed. Calling or shaking did not get any response.

The stroke had been received on the left side of the head over the anterior superior quadrant of the parietal bone, and a depression of the bone could be felt through the scalp and the wound. Before he became unconscious and after he was brought home, he spoke of a feeling of numbness and finally of paralysis in his right arm. Being satisfied from these symptoms that intracranial hemorrhage had taken place and was probably still going on, we proceeded at once to lift a U-shaped flap and cut out a disk of bone, which allowed more than an ounce of exuded blood to escape that had been compressing the motor area of the left side. Rather a fierce hemorrhage was set up from the middle meningeal artery that had been divided by the cut of the instrument. The orifice of the bleeding vessel was successfully plugged with a bit of chromatized animal ligature pointed and pushed into its opening, and as it lay in a rather deep groove in the bone, it was not without considerable difficulty that I at last succeeded in raising the depressed portion of the bone which, though broken with a Y-shaped or stellate fracture (but not parted), was so firmly inarched that it obstinately resisted for some time all my efforts for its restoration. The flap was now returned, drainage and sutures put in and the wound carefully cleansed, both beneath and upon the scalp, with a 1-in-3000 solution of the bichloride of mercury, and over all a dressing of antiseptic gauze and iodoform.

For several days he suffered pain about the seat of the injury and around his left eye and ear. Partial paralysis of his right

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arm and partial aphasia continued for about two months, but he eventually recovered with the total loss of the sight of his left eye.

I had a talk with him only a day or two since, and he says that he still has pain in the vicinity of the fracture, pain in his ear and around his eye on the same side as the injury. However, he is now engaged in getting saw-logs and camps out with his hands, says he can do a good day's work when the weather was cool, but could not stand the heat of last summer.

*Case 4.* Joseph B., 59 years old, farmer, was struck on the head with a heavy gun-barrel in the hands of an assailant. He fell to the ground and remained for a time unconscious, but finally arose without aid and walked 400 yards over a high hill to his home. Twelve hours after the injury I saw him with Drs. Wedding, Cox and Raine. He was still able to answer questions, but had at times been delirious throughout the day. On the right side of his head was a contused wound through which at one point was exuding blood and some cerebral substance. The left arm was paralyzed. The scalp being shaved and carefully cleansed with antiseptic wash, the skull was exposed, revealing a depressed comminuted fracture of the right parietal bone about four inches in length and two in breadth, one inch from and parallel with the sagittal suture. After removing the loose fragments and elevating the depressed bone, the ruptured middle meningeal artery, which had been bleeding more or less from the time the injury was inflicted, continued to furnish quite a free hemorrhage. The bleeding end of the artery was so situated that it could not be ligated, but was controlled with a tampon of iodoform gauze. The upper end of the middle third of the fissure of Rolando was probably just beneath the fragments that were removed, and the rupture of the membranes and laceration of brain substance a little in front of it.

The wound was now thoroughly disinfected with mercuric bichloride solution, drained, and the flap replaced. He slowly recovered and was present as a witness in the criminal prosecution of his assailant. There is still, however, partial paralysis of his left arm and a small sinus leading down to the fracture.

*Case 5.* Roberson, 36 years old, sawmill owner, had been struck on the head by a heavy piece of lumber, used as joist, which

slid endwise from a shed and knocked him insensible. He was carried on a batten two miles to his home, where he had been under treatment for two months by his physicians, when I was called. He was extremely emaciated and prostrated from his protracted suffering; could only get rest and sleep when under the influence of full doses of anodynes. The pupils were unequally dilated, that of the right eye being the larger. When awake his arms and legs were almost constantly in motion by a voluntary muscular contraction; the right arm and leg exhibiting less movement than the left. Temperature below normal in the mornings, with a rise to  $100^{\circ}$  in the evening, and going down with perspiration at night.

He would answer when called to loudly, but without intelligence, and seemed unable to control his speech, which was a mixed jargon of syllables and indistinct words. The seat of the injury did not show any signs of fracture or depression of the skull, or even any very distinct scar. But upon close examination the scalp seemed to be denser and bound tightly to the skull at that point. After shaving the scalp and thoroughly cleansing it he was anesthetized with chloroform and a U-shaped flap lifted, exposing the calvarium. After careful inspection neither fracture nor depression could be found. A conical trephine was put down, and a disk of bone removed at the point where the scalp had appeared to have been injured. This happened to be one inch to the right of the sagittal suture and about the same distance in front of the fissure of Rolando. Upon removing the button of bone a small quantity of pus escaped through the opening, and the dura mater was roughened with inflammatory deposit. There was not any bulging of the membrane into the trephine hole, nor other evidence of deeper suppurative action observed. A small branch of the middle meningeal artery which did not bleed at first furnished a considerable hemorrhage when patient was allowed to come partly from under the influence of the chloroform, and had to be plugged with a bit of aseptic cat-gut.

The wound was now cleansed with a 1-2000 bichloride solution and some threads of chromaticized catgut used for drainage, and the flap sutured in place.

Drs. J. W. Meadon and E. B. Pendleton assisted me in the operation, and Drs. Meadon and Wedding took charge of the

after treatment. Improvement did not take place immediately, but by the next day there was some change for the better. From this on gradual improvement continued until at the end of three months the patient was able to resume his vocation.

I had an opportunity to examine his head at the seat of the operation six months after the operation, and found the trephine hole closed with dense fibrous tissue. He said that he did not in any way suffer pain or inconvenience from it, and that he was able to bear as much labor as before he received the injury. He is now living at McHenry, in Ohio County, engaged in cutting lumber with his mill for the use of the mines.

The following case presented itself Nov. 8, after I had written a report of the cases I have read:

*Case 6.* Lena N., aged 13 years old, fell, striking her forehead against the sharp, projecting corner of a rock when five years old. The wound soon healed and nothing more was thought of the injury. She grew up and became more and more delicate, was sedate and not inclined to indulge in play with the other children; complained of headache, which from year to year became more constant. Within the last three years several physicians were consulted and prescribed for the cephalgia without giving more than temporary relief. She also suffered from obstinate constipation of the bowels, which seemed to be as intractable as the pain in the head. For three weeks before I saw her she had been kept in bed and laid in a listless state of indifference from which she could not be aroused. There had not been an evacuation of the bowels for eight days, nor had she swallowed anything but liquid food for four or five weeks previous to my visit. On that day her respirations were nine to the minute, pulse 54, and temperature 97°. Pupils contracted equally, and eyes sensitive to light. No paralysis could be detected, though she had frequently complained of tingling and numbness in her extremities. The extreme emaciation she had reached, together with the motionless dorsal decubitus of the body, kept so long that the bed clothing had adapted itself to the attenuated form, all reminded one unpleasantly of the presence of a cadaver.

A white cicatrix on the right side of the forehead, situated on the frontal eminence within half an inch of the sagittal suture, plainly marked the site of the injury she had received eight years before. Beneath

the cicatrix could be felt an indentation in the bone. While able to talk she had located the pain in the forehead around the vicinity of the scar, but no one thought to refer the pain to the old traumatism, as it had almost been forgotten.

With the assistance of Drs. Williams and Glen chloroform was administered, and a button of bone, including the indentation, was cut out with the trephine, after shaving the scalp and thorough antiseptic cleansing. The inner edge of the trephine cut was in contact with the superior longitudinal sinus, and the thickened edge of the disk was cut from a continuation of a ridge that extended into, if not across the sinus. The sinus was not laid open, nor was there any bleeding scarcely from inside the skull, but I have not seen so much bleeding from the vessels of the diploë as we encountered in this case. It was finally arrested, however, by the application of very hot water. I remained at the house till the next morning and left her apparently doing well. She had taken some milk and medicine and retained it all, which she had not done before in three weeks.

This operation was done as a forlorn hope, as in her extreme condition of exhaustion and emaciation there was nothing to inspire more than the most distant expectation of success. Should she recover, I shall forever feel grateful to the powers that come to our relief when hope is well-nigh spent.

The following is a report of some cases in which the trephine might have been used with the expectation of favorable results, but was not:

*Case 7.* B. A. was stabbed in the forehead in a drinking bout and a part of the knife blade broken off in the skull. He was in good health when about 26 years old, and a noted bully. Neither at the time, nor for two days after the injury did he complain, but continued to ride horseback over the country. The morning of the third day he began to suffer with headache, and by the evening he was raving in delirium and soon perished from encephalitis. At the autopsy it was found that the blade had punctured the brain to the depth of half an inch and remained broken off in the bone.

*Case 8.* W. C., 32 years old, was kicked on the left side of the head by a vicious stallion he was keeping. Soon recovered from the shock, got up and led his horse some distance to a house by the road, put him

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into the stable, went in the house and told the family circumstantially of how he received his injury. Complained of feeling badly and asked to be allowed to lie down. Soon after he got in bed he began to grow drowsy and to breathe heavily, and finally fell into coma and died within a few hours, evidently from compression produced by intra-cranial hemorrhage.

*Case 9.* G. B., aged 22, fell, striking his head on the ice, during the great sleet of two years ago. He was alone, some distance from home at the time, but succeeded in reaching there unassisted. He told his mother how he received his injury, complained of pain in his head and numbness in his arm. He went to bed and died of compression the following night.

*Case 10.* B. C., a child, male, about two years old, fell from a high door-step, head downward, striking upon a six-penny nail that protruded upward through a thin board that was lying on the ground. The nail punctured the scalp and the skull, entering the brain, and required considerable force for its extraction. The puncture was situated an inch or more from the sagittal suture at the junction of the anterior and middle third of the left parietal bone. The child cried a little at the time, but was soon pacified, played about the floor for half an hour or more, after which it fell asleep. When it awoke the right arm was found to be paralyzed. A physician was called in now and found the scalp puffed around the orifice. He passed a probe through the wound and let out three or four drachms of dark blood. The symptoms improved to recur again and again after relief in a similar way for three weeks. The operation of trephining was proposed and declined, and the child finally perished with encephalitis, coma and convulsions.

These four last cases reported are not all that I have seen within the time intended to be covered by this paper that might have been better by trephining, but I have selected them because the indications were most palpable.

Much as has been learned and published within the last two decades with regard to the functions of the cerebral centres, we are not yet in possession of sufficient knowledge to shield us from the danger of making mistakes in locating cerebral lesions. The very complex anatomical arrangement of the nervous centres and their conducting tracts, the facts that two or more areas may be

intimately connected with the same function and that lesions of the same location in different individuals may not produce like definite results, conspire to hinder correct diagnosis. All have doubtless recently read of some brilliant successes in brain surgery said to have been achieved by superior knowledge of brain localization, skilful operating, and the use of the aseptic and antiseptic methods of modern surgery. Tumors and abscesses embedded deeply in the brain substance that would have inevitably have terminated life have been extirpated or evacuated and the patients restored to health. Cases of traumatic epilepsy, with and without any apparent lesion at the seat of the original traumatism, have been subjected to operations that not only removed broad areas of the calvaria, but also made extensive resections of the cortical and subcortical brain substance. In one instance, in a confirmed traumatic epileptic, one-half of the whole breadth of the ascending parietal convolution was excised, the apex of the wedge reaching into the corona radiata, with the effect of permanent relief from the seizures.

Perilous as these daring ventures in brain surgery may seem, there will be found many whose lives have been made so miserable by constantly recurring fits of epilepsy, and who have failed of relief in all other directions, who will gladly avail themselves of almost any operation to get rid of their malady.

In syphilitic, tubercular and malignant growths of the brain the use of the trephine is rarely warranted, nor should I feel justified in its use when the growth was unusually large, or if there were signs of diffuse infiltration around a cerebral tumor with ill-defined focal symptoms and rapidly advancing evidences of compression. In depressed fracture, in sub-cranial or sub-dural hemorrhage, or in traumatic abscess, if the focal symptoms are of a reliable character, there should be no hesitation about operating. It has not been my habit to urge patients to submit to perilous operations. My custom has been to state the facts as I understood them plainly and then leave the matter with the patient and his friends. Judging from my own observation and all I have gathered concerning the conditions of the skull and brain for which trephining may be done, I can only say that the propriety of operating depends most upon our ability to make a correct diagnosis.

THE CAUSES OF FREQUENT FAILURE OF RELIEF OF REFLEX SYMPTOMS AFTER TRACHELORRHAPHY.<sup>1</sup>

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For many years trachelorrhaphy has been an unfailing fountain from which has been quaffed the inspiration for the preparation of papers written for the edification of medical associations and journal subscribers. Its beneficent results have been so lauded, its favorable statistics so completely tabulated, and the reflex phenomena excited by lacerations of the cervix so fully described by competent and incompetent observers, that every incipient gynecologist, when a case is presented to him suffering from a pelvic trouble, begins his investigation with a lacerated cervix in his mind's eye; and happy is the observer if he discovers the lesion.

Many years ago the physician who gave "especial attention to diseases of women" entered into the investigation of a woman's peculiar ailments with "ulceration of the cervix," and the custom prevails to-day to a large extent; if he found the desired lesion, he was in a happy frame of mind, with his little stick of nitrate of silver and his vial of fuming nitric acid by his side. If no ulceration existed, however, he was at a loss how to proceed, his resources being exhausted. So to-day the aspiring gynecologist who has advanced one step beyond his predecessor looks for the lacerated cervix, and failing to find it, finds himself in the same fix. Thus the world wags on and history repeats itself.

That the operation of "trachelorrhaphy" is a success when properly performed, in cases where it is properly indicated, there can be no controversy; but that trachelorrhaphy as performed is frequently not crowned with success, is a fact too patent for argument.

How often do patients come to our office despairing of relief, with the statement that Dr. —— has operated on her for the restoration of the neck of the womb, promis-

ing her perfect and permanent relief, and she is no better than before he operated. She further informs us that the doctor has assured her in unmistakable terms that after the operation she would feel like a "young girl in her teens," and that all of her pains and aches would be but a reminiscence of the past. Yet the old familiar aches and pains were present and mournful reminders that life in this world is anything but a bed of roses, and that the fond anticipations she had nursed of ease and contentment in her remaining years were but idle dreams and vain hopes, and as a consequence she has lost faith in curative means and is disposed to look on members of the medical profession as veritable humbugs and impostors.

The doctor himself who operated, astonished and disgusted at the result, looks over the statistics again, refers to Emmett, Thomas and other authorities, and is at a loss to know why in this individual case—his particular case, from which he had expected to gather shekels and renown—everything goes awry, and success fails to crown his effort. What is the trouble? he asks. The laceration has been repaired, the integrity of the "os" restored, and nothing is apparent to account for the lingering and unameliorated symptoms. Are statistics a lie, and is gynecology a fraud? The answer is plain. Gynecology is a science, the mysteries of which are apparent only to the student who applies himself to it as such, and a man may be a good doctor and not a gynecologist.

The misfortune for the patient and the science is that there are many ambitious practitioners, ungrounded in anatomy, physiology or pathology, who, desiring to pose as gynecologists, attend a course at some post-graduate school, and after witnessing a few operations by a Wylie, Mundé, Emmett or Thomas on a lacerated cervix, exclaim, "Eureka!" and hustle down to a surgical instrument factory and lay in a supply of tools, and hie away home with lacerated cervix on the brain, to graze on the green and fertile pastures lying thereabout in the pose of a gynecologist.

In a short time he reads a paper before his local society on the operation for lacerated cervix and gives his experience as to its beneficent results; not, however, letting it be known that his only experience consists in witnessing the operation at the hands of experts.

Next we hear from him in the local journal to which he is an honored subscriber,

<sup>1</sup> Read by title before the Southern Surgical and Gynecological Association, Nashville, Tenn., Nov. 14, 1889.

his theme still "lacerated cervix" and the beneficent results of trachelorrhaphy in his hands. He dreams of lacerated cervices, and in his dreams sees crowds of women broken down in health, bringing to him their lacerated cervices for repair, through one door, and the same crowd departing through the other door with restored health and strength and beauty and cervices, their countenances beaming with gratitude after having laid an abundance of shekels at his feet. The only thought marring the beauty and pleasure of his dream, the thought "suppose he should cut too deep some time and sever his circular artery, which he has heard lies somewhere in that neighborhood, wouldn't there be trouble?"

In a year or two, when his failures are more notorious than his successes, he subsides and re-occupies the plane for which his education fits him—that of a one-horse doctor—abuses his science of gynecology, and proclaims it a humbug where his voice is heard. In the meantime we receive contributions through the usual channels of medical literature from the Wylies, Polks, Emmets and others, proclaiming that the utility of trachelorrhaphy is from day to day more firmly established as performed by them. Why this discrepancy in results of observation? The answer is apparent. In the one case the operation is in the hands of an expert, in the other, of a pretender. The first trouble in the way of the non-expert is an inability to recognize the etiology of the reflex symptoms in a case where trachelorrhaphy alone is indicated.

Why is it, in other words, that the patient suffering alone from reflex symptoms, demanding the aid of trachelorrhaphy, can be relieved from all her reflex symptoms by the operation at the hands of one operator, the laceration being repaired, while at the hands of another operator, "non-expert," no relief is obtained, although the rent has been repaired? Let us consider what is causing the reflex symptoms.

I have two cases now in remembrance, who have extensive lacerations, discovered only while the patients were giving birth to children, and evidently of long duration, who declare they have never had a symptom of a reflex or direct character leading them to suspect any uterine trouble whatever.

Some years ago I met with a very clever practitioner of medicine, whose reputation extended far beyond his field of labor, and he asked the question: "Why is it that Sims

goes along incising the lips of the cervix uteri to cure disease and relieve reflex symptoms, while Emmett, his most distinguished pupil, comes along and sews up the divided cervix for the cure of disease and reflex symptoms?"

When Sims recommends the section of the cervix it is made in normal tissue and the face of the incision heals over and is covered with a soft pliable cicatrix resembling the mucous membrane. On the other hand, when Emmett repairs a lacerated cervix it is in an abnormal and diseased condition. What are the facts in the case from which we draw our later deduction?

When a woman becomes pregnant there immediately ensues a physiological process, known as evolution. This process continues during the whole period of gestation. As a result of this process, cells are abundantly deposited in the substance of the uterus, both body and cervix, in order that the organs may have abundant material or body to prevent rupture and give muscular power to expel the product of gestation at the proper time. Not only does the product of evolution increase the muscular, but also the arterial, venous and nervous structures of the organ.

After gestation has ceased, and the contents of the organ are expelled, a physiological process called involution is established, by which all of the products of evolution are removed and absorbed into the general system, and the uterus and cervix, if this process proceeds in a normal manner, in a few weeks assume the same conditions that obtained previous to the pregnancy. But in a given case, during the process of labor, this cervix, enlarged and laden with the products of evolution, gives way and is ruptured. What is the result? Inflammatory action is established at the seat of the lesion, which by the ordinary physiological processes is healed, but this inflammatory process, so necessary for the healing of the broken surfaces of the wounded cervix, puts an immediate stop to the process of involution in the torn tissues and *fixes* the products of evolution within the area controlled by reparative inflammatory action and a hyperplastic condition of this part is permanently established. The ultimate filaments of the cervical nerves permeating this area are engaged in this pathological plasma which, after the reparative inflammation has subsided, undergoes a process of consolidation and condensation, and the pressure on these ult-

mate nerve filaments is responsible for the many reflexes following cervical lacerations. Here we have a case as it presents itself to the embryo gynecologist. What are his ideas and what steps does he take? He recognizes the laceration and proposes to operate, assuring the patient of a cure, for has he not with his own eyes seen Hanks or Hunter cure exactly such cases? He places his patient under ether on the table and goes to work on the laceration. With his scissors he denudes the surface and brings the lacerated parts together. Perhaps it heals and perhaps not, but in either case the patient suffers as before. What is the matter? Simply not realizing the pathology of the case, he has failed to dissect out all the scar tissue; and the ultimate filaments of the uterine nerves are subject to the same pressure as before the operation; in fact, it really makes but little difference whether union of the denuded parts ensues after the operation or not, if all the hard scar tissue be thoroughly dissected out and removed.

We have here, then, one of the frequent causes of the failure to relieve reflex symptoms from trachelorrhaphy. A failure to remove every vestige of hardened tissue—fixed products of evolution.

I now desire to call your attention to another frequent cause of failure to relieve reflex symptoms from diseased pelvic organs by trachelorrhaphy, and that is *insufficient diagnosis*. Let us bear in mind that all the pelvic viscera are supplied with nerves from the hypogastric plexus and the pelvic plexus of the sympathetic nerve, and that through the medium of these nerves reflex symptoms are produced. Considering this fact we can readily understand that the same reflex phenomena may be, and frequently are produced by lesions of different organs. Thus while in a given case we find certain pathological phenomena accompanying a lacerated cervix, we at other times observe similar phenomena accompanying an hyperplastic condition of the broad ligaments, or a laceration of the perineum, or an organized effusion following a pelvic peritonitis. Why? Because the sensation, if I may use the term, carried to the lumbar and sacral ganglia is the same whether it be from the irritated ultimate filaments distributed to either of these localities. It is true that a lesion in each locality frequently carries with it some peculiar reflex symptom not common to the lesion of other localities, and to the acute observer an indication is

given that a certain organ is suffering; but let the observer beware of attaching to such an indication undue prominence, and resting his mind on the assurance that the organ in which he has discovered a lesion is the only one diseased; for the majority of reflex symptoms are common to lesions of different organs of the pelvis.

The embryo gynecologist who has "laceration of the cervix" on the brain, when he finds no laceration present, is at once lost in a wilderness of doubt, failing to find the lesion he expected to treat, and is unprepared to investigate further, and falls back on the stick of caustic that he used to rely on before he became a gynecologist, and bewails the fact that his patient failed to have a laceration that he might cure, knowing that she could not have two diseases at once; like the quack of history who gave all his patients camphor to throw them into fits, because he was death on fits.

A remedy that would convert all pelvic diseases into lacerated cervices would be a Godsend to this kind of gynecologist; and, alas! for the credit of the profession and for suffering womanhood, their name is legio. Let it be noted that no gynecologist, I care not who he may be, is prepared to diagnose and treat a case until he has given *all* the pelvic viscera a systematic and complete investigation, and when disease is discovered in more than one organ or two or more diseased conditions are present in the same organ, his efforts must be directed to the treatment of *all* diseased conditions.

We are aware that a lacerated and hyperplastic cervix frequently acts as an exciting cause to establish lesions in other organs or other lesions in the same organ and of the other fact, that it is generally supposed by the class of gynecologists to whom we have had cause to allude heretofore, that when the primary lesion is cured its resultant lesion will be restored to its normal condition without further treatment. Thus, for instance, in case of a lacerated cervix we frequently find endometritis or ovarian irritation and enlargement probably primarily caused by the lacerated cervix, and it is expected the cause being removed the effect will cease. While this axiom is true when applied to functional disturbances alone, it does not hold good in those cases when a lesion has been produced and change in structure has taken place. These secondary lesions must be treated as if they were primary in their character.

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Not long ago a patient came under my observation, an invalid of seven years' standing, since the birth of her last child in fact, weighing 90 lbs., unable to walk any distance without great pain. All her symptoms pointed to some lesion of the pelvic organs. Upon examination the first thing presenting itself to the observation was the expected lacerated cervix, but upon further investigation the ovaries were found enlarged and tender, the right broad ligament excessively tender, thickened and shortened and evident remains of a peritoneal inflammation. The lacerated cervix was in sight; the other lesions had to be sought for with "tacitus eruditus." My impression was that I had a case for trachelorraphy after the other lesions were remedied. A course of appropriate treatment for six weeks regulated the patient's bowels, restored her menstruation, which had been absent seven years, restored her ovaries to a normal condition, produced absorption of hyperplastic material in the broad ligaments, removed all traces of remains of peritonitis, restored her appetite, increased her weight 34 lbs., enabled her to walk any distance without pain, and restored her to perfect health; and no operation on the cervix was required.

This was one of the many cases in existence which, falling into the hands of the average gynecologist of the day, if reported would have added another to the statistical figures going to prove that trachelorraphy frequently fails to cure reflex symptoms caused by a lacerated cervix.

When diagnosis is thorough, by a competent observer, and all other causes of reflex action justly excluded, being confined strictly to a lacerated cervix, trachelorraphy properly performed is a magnificent success.

#### PULMONARY AUSCULTATION DON'TS.

BY THOMAS J. MAYS, M. D.;  
PHILADELPHIA.

Don't auscultate in a cold room.  
Don't auscultate over the clothing.  
Don't auscultate a chest before percussing it.

Don't stoop while listening to a chest.  
Don't practice immediate auscultation, but select a good stethoscope and familiarize yourself with its peculiarities.

Don't forget that the hair on the chest

give rise to crackling sounds under the stethoscope.

Don't forget that your own beard or hair may do the same in any mode of auscultation.

Don't suppose that a double stethoscope is better than a single one because it enables you to listen with both ears.

Don't forget that you can hear best with a double stethoscope when it is held in a straight line.

Don't fail to take into account that a metallic stethoscope imparts a metallic tone to all chest sounds.

Don't buy a stethoscope in which the stem does not go through the ear piece entirely; for the stem is the principal conductor of sound, and thus insures complete continuity of material from the chest walls to the ear.

Don't lean hard on the stethoscope.

Don't allow clothing or your fingers to rub on the stethoscope while you listen.

Don't auscultate with any silk material between the patient's skin and your ear.

Don't ever omit to auscultate the apices and bases thoroughly.

Don't neglect asking your patient to cough when you are in doubt as to whether a râle is located in the alveoli or bronchi: if in the latter it will be dislodged.

Don't fail to realize that râles in one interscapular region are sometimes reflected into the opposite healthy lung through the medium of the large bronchial tubes; and that a large râle or ronchus in one of the main bronchial tubes may be transmitted over the whole or a greater part of the chest.

Don't set too high a value on a single physical sign; always endeavor to find corroborative ones.

Don't fall into the common error of believing that the crepitant râle never disappears under examination. This takes place when freshly developed crepitation is not too profuse and is subjected to repeated forced inspirations.

Don't regard a slight click at the end of inspiration, or at the beginning of expiration in an apex, as a trivial sign.

Don't forget that, as a rule, the crepitant râles at the base are more moist and crackling than at the apex, and that the latter are more resistant to treatment than the former.

Don't think, if you find a wavy or jerking respiration, that it is always a danger signal.

Don't place too much reliance on vocal resonance or bronchophony.

Don't fail, in listening for prolonged expiration, to ask your patient to breathe through his mouth. This will prevent those sounds which are produced in the nares from being transmitted into the lungs.

Don't say blowing expiration for prolonged expiration. In auscultation parlance blowing applies to inspiration.

Don't overlook the fact that creaking and crumpling râles in an apex may indicate an old dry cavity.

Don't accept the common teaching of some text-books that the pitch of expiration in a cavity is always lower than that of inspiration.

Don't omit to remember that in a good-sized cavity in the left lung the heart sounds occasionally produce a metallic reverberation.

Don't conclude that owing to the absence of well-recognized signs of disease in the chest, there exists no phthisis, when wasting, cough and fever persist.

Don't fail to record the physical signs and symptoms of every case you examine.

George L. Peabody, of the College of Physicians and Surgeons, which, a few years ago, would have been regarded as rank heresy and one which would be almost certain to be followed by untold mischief. This was the use of solid food at the end of the third week or during the fourth week in the case of patients who are hungry and yet who still have more or less fever. In such cases he allows a small portion of tender steak or chop very finely subdivided, and, in addition (though at a different hour) the half or the whole of an egg; and he stated that he had never seen any evil result from this practice, while in many instances it has been followed by great benefit in the increased strength of the patient. In his opinion food, such as that referred to, is really digested before it gets well into the intestines in the case of those who, during some part of the twenty-four hours, are free from fever. As to the matter of relapses, he said that he was inclined to believe them to be due to a reinfection of the system, and that far more mischief was apt to result from allowing the patient to get up from bed too early than from giving him properly prepared food of a suitable character.

Dr. J. West Roosevelt expressed great gratification at having the views of Dr. Peabody, and stated that for some time past he had been tentatively pursuing the same plan, although with more or less fear and trembling on account of the strong feeling that had hitherto prevailed against the use of solid food in typhoid.

Professor E. G. Janeway spoke of the *febricula* of typhoid fever, which, he said, was not generally recognized. Where an outbreak of typhoid occurred in an institution he had sometimes found that while a larger number of the inmates are attacked with all the characteristic symptoms of the disease, in a considerable proportion of these the affection ran a very brief and mild course; which in his opinion went to show the capacity in certain individuals to throw off the disease, even after the usual phenomena accompanying had made their appearance. There was always danger, he said, of the attending physicians in such an attack regarding such cases as having been abated by the treatment employed, while in reality the same results would have been noted if no treatment whatever had been resorted to.

It was noticeable that Dr. Janeway expressed, in strong terms, his continued confidence in the use of the newer antipy-

## NEW YORK CORRESPONDENCE.

*New York Academy of Medicine.—Antiseptic in Typhoid Fever.—Solid Food in Typhoid.—Febricula of Typhoid.—Modern Antipyretics.—The Prevailing Epidemic.—Relation of Patient's Age to Influenza.—Complications of Influenza.—Bronchitis and Pneumonia in Influenza.—Execution by Electricity.*

At the last general meeting of the New York Academy of Medicine, Professor Wm. H. Thomson, of the University, read a paper on the treatment of typhoid fever, and the feature of the management on which he laid the greatest stress was intestinal antiseptic. This he believes is most successfully carried out by the administration every three hours (and in some cases every two hours) of ten grains of saccharated pepsin and ten grains of subcarbonate of bismuth; in addition to which he often gives ten minimis of dilute muriatic acid at the same intervals. As one result of this treatment he claims a great diminution of tympanitis, and the prompt checking of diarrhea; and, as a rule, he never resorts to the use of opiates.

In the discussion which followed the paper, one measure was advocated by Professor

retics such as antipyrine, which, if used with proper caution, he claimed were not attended with any bad results, and though not possessing any curative power in the disease, secured the greatest possible comfort to the patient with the least possible disturbance. If the heart showed signs of weakness he thought it well to give with them one of the cardiac stimulants, such as digitalis, caffeine, the ethers, or camphor. He gave a note of warning against the use of straphanthus in typhoid, for the reason that he has of late found this agent to produce diarrhoea in a number of instances. On the whole, he considers camphor one of the best remedies that we can use in this disease, as it not only strengthens the heart, but is an excellent antiseptic. It should be stated before leaving this subject that while in the vast majority of instances Dr. Jane-way prefers medicinal antipyretics, he has found that in certain exceptional instances they prove inefficient, and in these he resorts to the external application of cold in the form of baths.

At the January meeting of the Section on Theory and Practice of the Academy of Medicine there was a discussion on the prevailing epidemic of influenza, in which more points worthy of note were brought out. Dr. C. L. Dana, the well-known neurologist, said that, according to the published reports, the affection commenced in St. Petersburg about the middle of November, and in New York about the middle of December, and that, while the whole course of the disease showed conclusively that it must be due to a specific germ, it was manifestly impossible (reasoning from our knowledge of other infectious germs) for such a contagion to travel this long distance in the short space of one month. We are therefore forced to the conclusion that the germ was already in this country, and that the microbe of epidemic influenza is not borne by the wind, or carried by individuals, like the cholera germ, but is distributed throughout the world. It had been claimed in Vienna, he understood, that this microbe had been found; but, in the experiments undertaken, it had failed to reproduce the disease, and he did not believe, therefore, that this important discovery had yet been made. In addition to the action of the specific germ, there seemed to be concerned in the production of the disease some epidemic influence, whether telluric, electric, or what not; although the speculations on this point had

not as yet proved very fruitful. Dr. Dana then made some remarks on the nervous manifestations of the present epidemic as they had been noted in his own experience, and in the course of them stated that its most characteristic nervous phenomenon was the prostration so commonly met with. This, as in the case of other zymotic affections, he was inclined to believe was due to the direct effect of the poison of the disease upon the heart.

Dr. W. P. Northrup spoke particularly in regard to the ages of the patients attacked. In the New York Foundling Asylum, where there are over 700 inmates, he said that not a single diagnosis of influenza was made among the infants under two years of age. Among the children between the ages of two and five something like 15 or 20 per cent. were attacked, and all the children rapidly and completely recovered. All the severe cases (with pneumonia, etc.) were among the adults in the institution who were between the ages of eighteen and twenty-five; and of the total population of the house between two and twenty-five years old, about 80 per cent. had the disease. Out of fifty-two old ladies in a home where Dr. Northrup attends only two were attacked, while among fourteen younger women who are attendants in the institution six cases occurred. One curious feature of the influenza at the Foundling Asylum was that one ward entirely escaped the disease, although it was not in any way isolated and there were numerous cases in the wards adjoining it. The pregnant women awaiting confinement in the Maternity also escaped. Dr. Northrup has met with two cases in which there was a well-marked erythematous eruption symmetrical on the two sides of the body, one in hospital and the other in private practice. In one of these the temperature rose to  $103^{\circ}$ , there were green vomiting, angina, and intense itching and burning, and the whole attack closely resembled scarlet fever.

The eye and ear troubles attending and following attacks of influenza were described by the specialists, Dr. T. R. Pooley and O. D. Pomeroy, and the former stated that, during an attack in his own person, he took great interest in studying the eye symptoms. Disease of the ear appears to result much more frequently than that of the eye, and is usually of the character of purulent otitis, which is often accompanied by perforation of the ear-drum, and is due to the spreading of an inflammatory process from the throat

through the Eustachian tube to the middle ear.

By request, Professor Francis Delafield, who has just been elected chairman of the Section, gave his experience in regard to the bronchitis and pneumonia met with in connection with the epidemic. Like every one else, he said, he had been struck with the frequency with which these two diseases have occurred. In regard to the former two things had especially attracted attention. The first was the very satisfactory way in which the apparently very bad cases got well. Often there was great difficulty of breathing, with considerable rise of temperature, and expectoration of blood as well as mucus; yet he had been surprised to see how well such patients had done, and how quickly improvement set in. The second point was the number of individuals who, while they had a general bronchitis as far as the large tubes were concerned and localized bronchitis involving the smaller tubes, yet remained free from any implication of the lung tissue.

As to pneumonia, he thought every one must have been impressed with the frequency with which this disease was accompanied by bronchitis. In these cases of pneumonia he said there was a considerable difference, and that he had observed altogether four classes. In the first the cases were very mild. The temperature did not run high and there was very little dulness on percussion. There were some subcrepitant râles over a portion of the lung; but they cleared up within a few days.

In the second class of cases the patients did not seem to be very sick, and did not have a very high temperature, but they had considerable bronchitis and perfectly well-marked consolidation of one lobe which lasted for a week or two.

The third class was composed of those who had fully developed consolidation of the lung which went on for quite a long time. The temperature rose perhaps to  $104^{\circ}$ , and did not go down. After ten, or even twenty days it would still be found that the consolidation had not cleared up. In many instances, however, even after this very long period, the lung did clear up, the temperature went down, and the patient got well.

The fourth class was made up of the very bad cases. In most of these, together with the pneumonia, there were evidences of a great deal of bronchitis. The action of the heart was poor, and stasis of blood in the

veins resulted. When this condition had been established the heart's action was very rapid and feeble, and expectoration became suppressed. Such patients seemed to do badly, no matter what course of treatment was pursued. Some seemed to be relieved for a day or two, and then the grave symptoms all came back again. In a smaller number death occurred as in ordinary lobar pneumonia.

The apparatus which has been placed in the three New York State prisons at Sing Sing, Auburn and Dannemora, for the execution of criminals by electricity, has all now been satisfactorily tested by a committee of experts, consisting of Dr. Carlos McDonald, Chairman of the State Commission in Lunacy, Dr. A. D. Rockwell, Professor of Electro-therapeutics in the New York Post-Graduate Medical School and Hospital, and Professor L. H. Landry, of the School of Mines, Columbia College. The last test was made at Dannemora prison in the latter part of January, when a powerful bull was instantaneously killed, without a struggle, by a charge of only 900 volts, while in the electrical executions it is proposed to employ a voltage of 1,500 to 2,000.

## PERISCOPE.

### Etiology of Influenza.

The *Wiener medizinische Blätter* of January 23, publishes a "preliminary communication" on the etiology of influenza, by Dr. Maximilian Jolles, of Vienna. After protesting against the undesirable publicity which his investigations, which are still incomplete, have obtained in the political press, he goes on to say that, while making bacteriological examinations of the sputa of patients suffering from the prevailing epidemic, he was repeatedly struck by the fact that in the cover-glass specimens there were exceedingly numerous "capsule cocci," closely resembling Friedländer's bacilli of pneumonia. On December 27 he received from Dr. Hanc, of Vienna, the urine of a patient for examination, the analysis of which gave the following results: Alkaline urine of diminished specific gravity (1.01); chlorides diminished (3.834 grammes in a litre); small quantity of albumin and protein; triple phosphates; urate of ammonia; numerous leucocytes; mucous threads; pro-

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tatic corpuscles; numerous basement epithelial scales from the bladder, the neck of the bladder, the posterior and former parts of the urethra. These conditions seemed to prove that the case was one of acute purulent cystitis. Dr. Hane, however, asserted that there was no symptom pointing to a local affection of the bladder except high fever, which had come on suddenly, and a large amount of pus in the urine. On the second day Dr. Jolles received the urine of the same patient, in three portions; examination of it gave the same results, but as there was a family history of tuberculosis, Dr. Jolles made "cover-glass specimens" of the sediment of the urine, which he stained according to the method of Gabbett-Ernst. There were no tubercle bacilli, but there were capsuled cocci, which were quite analogous to those detected in the sputa. The same conditions were found in cover-glass specimens which had been stained with the usual aqueous aniline colors. Since then cover-glass preparations were made of the sediment of urine in all cases of influenza, and the capsule cocci were found in the vast majority of them, though not in all. These observations led Dr. Jolles to suppose that the micro-organisms discovered probably stood in an etiological relation to influenza, especially as capsule cocci have not before been detected in the urine. He made plate cultures of several specimens of sputum and urine, and as early as the fourth day he found colonies closely resembling those described by Friedländer. They appeared as round, sharply limited, yellow, granular discs; over the surface they had the appearance of semi-globular buttons resembling porcelain. Control cultures showed the characteristic nail form, but on a comparison with Friedländer's cocci cultures, the "knob" of the nail appeared to be less glistening and more granular. The behavior of these micro-organisms to aniline colors was the same as that of Friedländer's bacillus. By means of aqueous aniline colors Dr. Jolles obtained from the pure cultures short and thick little rods (bacilli) with round ends, which lay in couples beside each other, and touched each other with their narrow ends (without capsules). When treated after the method of Gram, the micro-organisms became discolored. In making a bacteriological examination of the Vienna Hochquell water (aqueduct water which supplies Vienna, and comes from the mountains) on December 26, Dr. Jolles found

numerous saprophytic bacteria (228 in one cubic centimetre) which in part liquefied gelatine, and in part failed to do so, and also numerous similar nail colonies which, observed with the microscope, proved to be diplococci, which were surrounded by a bright halo. The time has been too short to allow of satisfactory experiments on animals. A rabbit, in which a pure culture of one of the above-mentioned sputa was injected subcutaneously, remained quite well, and a second died of septicaemia, on the fifth day. It should, however, be borne in mind that these animals are refractory to Friedländer's bacillus.—*British Med. Journal*, Feb. 1, 1890.

#### Menthol in Affections of the Throat.

Mr. W. Frazer, in the *Med. Press and Circular*, Jan. 29, 1890, says: The suggestive paper of J. Lennox Browne, F. R. C. S., on the practical application of menthol, has reminded me that I ought to have called attention to some results of investigations made respecting its action in the course of last year. The first supply of menthol was brought to me direct from China, and the gentleman who obtained it for me said it was a well understood popular application in all cases of face-ache and brow ague, and sold in China by a class of hereditary traders, who, father and son, for many generations trafficked exclusively in menthol as a *specialité*. Since that time it has been extensively introduced into this country, and become a well-known article in chemists' shops.

I was so impressed with a conviction of its decided local anaesthetic powers that in the course of last summer I got Mr. W. Allen, of Henry Street, to prepare for me at his pharmaceutical establishment, compressed pellets containing definite quantities of menthol combined with certain proportions of cocaine, and presented this combination with considerable benefit in several cases of relaxed sore throat and pharyngo-nasal catarrh. I have no experience in its use in acute rhinitis, and so far as I have tried it in the prevalent catarrhal symptoms of epidemic influenza, now so widespread in this city, it has not proved of much advantage, still I am convinced that menthol alone or in combination with cocaine will be found a valuable aid in treating relaxed conditions of the throat and uvula. The use of its vapor is a suggestion

worthy full trial. There is always a liability to expect too much from a novel remedy, and when it does not answer all our expectations to undervalue it. I could not rely on menthol as a disinfectant in influenza, for I still want satisfactory proof that epidemic influenza is due to any contagious action, like scarlatina and ordinary exanthems, and can be in any degree controlled by any known deodorizer or disinfecting agent.

### Recovery after Symptoms of Acute Obstruction without Operation.

Spontaneous cure in acute obstruction of the intestine is extremely rare, and the following case, communicated by Dr. Behrens to the *Deutsche Medicinische Zeitung*, is therefore of interest. A woman, sixty-one years of age, suffering for about eight years from diabetes mellitus in a mild degree, carried some heavy domestic utensil from one room to another, and in placing it on the floor stooped quickly, when she immediately felt a stabbing pain in the right hypochondrium, which compelled her to lie down. During the next night she suffered from malaise, with inclination to vomit, and the bowels refused to act. The patient felt very ill, and cathartics as well as enemata with castor-oil and honey were unsuccessfully employed. The second night violent vomiting occurred, with continual pain in the epigastrium, and calomel with opium were administered, but likewise without giving relief. The vomit had a fecal odor. Dr. Behrens wished to operate without further delay, but the patient refused. About five hours afterwards he was recalled, when he found that the second powder of calomel with opium had induced a thin motion of a very bad odor, and that the patient felt considerably better. Vomiting and pain entirely ceased with the first motion, and the woman gradually recovered. —*Lancet*, Jan. 18, 1890.

### Sedative and Expectorant Mixture.

Dr. J. B. Johnson, of Washington, D. C., has found in his experience that no class of medicines is so suitable for the treatment of the inflammatory affections of the mucous membrane of the air passages, as alkalies. They not only relieve inflammatory action of the mucous membrane, but render its secretions more liquid, and, therefore, more

easily expectorated. He always relies for success in the treatment of inflammation of the air passages upon alkalies, whether the case be one of pneumonia, acute bronchitis, or influenza.

The following prescription is the combination most frequently used :

R	Ammonii chloridi						
Potassii iodidi							
Potassii chloratis . . . . .	aa 3j.						
Tinct. digitalis . . . . .	f 3ij.						
Tinct. scillæ . . . . .	f 3ij.						
Syrupi simplicis . . . . .	f 3ij.						
Aqua destillatae . . . . .	f 3iv.						

M. Sig. Shake well. Dose, a tablespoonful every two hours.

Should the cough be very troublesome and the inflammation not very great, two or three drops of the fluid extract of opium may be added to each dose.—*Southern Clinic*, Feb., 1890.

### Syrup for Certain Cutaneous Maladies.

Augagneur, the well-known dermatologist, publishes the following remedy, which succeeds admirably, he says, in prurigo and dry eczema :

R	Carbolic acid, 3j—3ij:						
Glycerine, q. s. to dissolve							
Syrup of orange, f 3 xij;							

M. Sig. A tablespoonful morning and evening.

—*Medical Press and Circular*, Jan. 29, 1890.

### Cooking.

From experiments made by Jensen in the laboratory of the University of Tübingen, it appears that raw meat is much sooner digested than cooked meat. Cooking, as far as animal food is concerned, has the effect of making it more pleasing to the taste, but is unnecessary; whereas, with certain vegetables, especially those composed principally of starch, as grain and potatoes, it is required to fit them for use. The proper preparation of food is a question that has not received the attention it demands. A badly cooked meal is more apt to disorganize the system than to prove nutritious and beneficial. The general teaching of cooking in our schools, both public and private, to girls would undoubtedly result in much improvement in this regard.—*Science*, Feb. 7, 1890.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

#### THE CARE OF EPILEPTICS.

There is no subject in the round of medical practice more deserving of deep and careful thought than the proper care of persons afflicted with epilepsy. These persons are among the most unfortunate that come under the notice of medical men; and their condition is so nearly hopeless, in the usual acceptation of the term, that it is hard to understand how so little has been done on a large scale to relieve their misfortunes. It is estimated that there are over one hundred thousand persons suffering with epilepsy in the United States; and we believe there is no public institution in the country devoted solely to the care of epileptics, except a small one in Massachusetts. In Germany there is an institution which now enjoys a world-wide reputation, on account of the nobility of its origin, the extent to which it

has grown, and the great good which it has accomplished. This is the Bethel Epileptic Colony, at Bielefeld, near Hanover, where there are now more than two thousand inhabitants, including patients and their caretakers. In the winter of 1886-1887, Dr. Frederick Peterson, of New York, visited this interesting colony, and since then he has repeatedly called attention to the beneficent work which it has done, in the hope that its example might be followed in our own land, where so much time, labor and money are devoted to the amelioration of the lot of different classes of unfortunates.

In a paper read before the Section of Public Health of the New York Academy of Medicine, Dec. 6, 1889, and published in the *Journal of Nervous and Mental Diseases*, December, 1889, Dr. Peterson gives an admirable account of the Bethel Colony and the methods of medicinal and hygienic treatment of epilepsy in use there, as well as of the general management of the institution. This paper is so full of instruction and of suggestion that we take pleasure in laying before the readers of the **REPORTER** some of its statements.

The founder of the colony at Bielefeld was a Lutheran clergyman, Pastor Bodelschwing, who about thirty years ago purchased a farm and began his work with four epileptics under his care. The institution gradually expanded into the present colony. In the twenty years from 1867 to 1887 more than two thousand epileptics had been treated there; and of these one hundred and fifty-six had been cured and four hundred and fifty were improved, while all were placed in circumstances most favorable to make their condition tolerable or even relatively comfortable. The colony is now a village of fifty-five houses, scattered over three hundred and twenty acres of woodland and meadow. Manual training is combined with educational and religious facilities in the colony, and to these are added the most careful and skilful medical treatment, together with a great variety of pleasing

amusements. In managing the patients great attention is paid to securing proper bodily and mental exercise, and carefully regulated diet, with suitable hygienic and medicinal treatment. In regard to the latter, it may be noted, in passing, that the experience of the colony has led to the conviction that no drug or combination of drugs gives such good results as the administration of pure bromide of potassium in water—about twenty-five grains a day. If the seizures diminish in frequency, the same doses are given; if not, they are increased to four daily in the second week, five in the third week, and so on until eight such doses are taken daily if necessary. If eight prove injurious mentally or cause severe eruptions, particularly on the legs, the dose is again gradually diminished. In many cases minimal doses only are borne and are persisted in for indefinite lengths of time. The above dosage is for patients over sixteen years of age. From ten to sixteen years, three doses are given daily at first and never more than five or six. Under ten years two such doses are given daily and they are increased to four. Very young children are given still less.

Special pains are taken to procure a thoroughly pure drug, as the bromide generally sold contains impurities, such as chlorate of potash and other foreign substances; often to the extent of six per cent. An especially pure drug is prepared for the colony, containing not above 0.5 to 0.7 per cent. of foreign matter. Even after the cessation of attacks the remedy is persisted in with gradually lessening doses, for as long as eight to nine months.

Dr. Peterson's paper contains so forcible a presentation of the great good which is being accomplished by the Bethel Colony that we can heartily commend it to the attention of the readers of the *REPORTER*; and we join in his hope that some public sentiment may be aroused as to the necessities of this neglected class of defectives, and that some religious sisterhood, some private

philanthropist, or some public official may be incited to provide for the early establishment in this or some other State of an epileptic colony, which shall become a home for the homeless, a place of refuge from many miseries, an educational institute for those who are forbidden the public schools, an industrial college for those to whom the ordinary avenues of trade are closed, a hospital where cure or palliation shall be possible, and where the highest scientific minds may be enabled to discover sometime a specific against one of the most woful of human ills.

#### CREMATION.

The readers of the *REPORTER* have now had an opportunity to learn the views of a very large number of the members of the medical profession in the United States on the subject of the proper mode of disposing of the bodies of the dead, and can see how strongly the opinion tends to approve of cremation instead of inhumation. The reasons given for preferring cremation to burial have been, for the most part, founded upon the general belief that burial of the dead near human habitations, and especially near the sources or conduits of water-supply, cannot be regarded as without prejudicial influence upon the public health. It will be remembered that some medical men, whose position as scientific investigators make their views of great weight, plainly repudiate the idea that disease is communicated from buried corpses to living human beings by means of emanations leaking into streams or wells near burying grounds; and this opinion is held by the *REPORTER*. None the less does it appear that the proximity of burial grounds to water sources or water conduits is undesirable, and there is force in the general objection to a mode of disposing of the dead which often involves this very condition.

The general preference for cremation apparent in the interviews published in the *REPORTER*, is further supported by what

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seems to be a growing feeling against the details of burial and its subsequent processes of decay. Physicians, as a rule, are not disposed to excesses of sentiment, and they regard with a certain amount of indifference the usual steps of development and disintegration which the course of nature includes. But physicians are not unmoved by the appeal made to their feelings, when it is proposed to substitute for the seen and unseen repulsive features of ordinary burial and slow decomposition, the rapid and unobjectionable reduction of the body to its original elements; and, for the almost certainty of neglected graves, a simple and easy mode of securing respectful care for all that is tangible and visible of those who have left the world.

So far, it is plain from what we have ascertained for our readers that the opinion of the medical profession in this country is strongly in favor of cremation as a substitute for burial of the dead, and it appears also that this opinion is growing more widespread as the subject is being more thoroughly discussed.

#### THE GRIPPE AND ITS NAME.

Considering that the present epidemic has, as yet, been by no means satisfactorily classified, it is rather amusing to glance over the remarkable names which it has been given. Coming originally from St. Petersburg, it started out, on its tour of the world, as "the Russian Influenza" or "Russian Catarrh." Its sudden onset caused the profession in France to designate it as "*la grippe*," and "*fièvre catarrhale épidémique*"; the German journals call it "*Grippe*," "*Blütkatarrh*" or *Die Russische Krankheit*." The medical journals of Italy have no uniform name for it, but speak of it principally as the influenza or "*catarro Russo*." The Spanish call it "*influenia Rusa*"; the Swedish, "*Ryska snufvan*" and "*nyssjuka*." In Norway and Denmark it has been given the name of "*nysesyge*."

In England, it has been called "bronchopneumonia" and "infectious bronchitis," also "contagious catarrh." In Cuba it is spoken of as *la componte*. In the United States the name "Harrison Grip" has been offered, in remembrance of the "Tyler Grip," of 1841, and it has also been termed "epidemic febrile catarrh." In Europe some have called it dengue fever; others, not wishing to commit themselves, have given it the compound title of "Grippe or Dengue," leaving the preference to the reader's choice. Perhaps its most original name is that given to the disease by a noted English physician, who has called it "bastard pulmonary rheumatism."

The variety of names proposed indicates the differences of opinion entertained in regard to the nature of this curious and serious disorder. As a matter of fact the disease appears to us to be so unlike any which has yet been fully described in the books as to deserve a special name. It is not influenza and it is not dengue, though it has at times symptoms like those of one or other of these disorders. For the present, the term "Grippe" seems the best, because it does not imply identity of nature with any other disease, and leaves the field open for a more exact and accurate designation whenever the nature of the disorder may be better understood.

#### BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the *REPORTER*.]

**STUDENTS' AID SERIES, Volume I. Aids to Diagnosis, Part I, by J. MILNER FOTHERGILL, M. D. Aids to Diagnosis, Part II, by J. C. THOROWGOOD, M. D. Aids to Diagnosis, Part III, by J. MILNER FOTHERGILL, M. D. 8vo, pp. 202. New York: G. P. Putnam's Sons, 1889.**

This first volume of a new series of small textbooks for students, contains three parts, the first and third by Dr. Fothergill, and the second by Dr. Thorowgood. The first part is devoted to symptomatology, the second to physical diagnosis, and the third to "What to Ask." The first two parts are fairly uniform in type and general arrangement of headings; the third part is in a different type, and has a different arrangement. The whole book is very poorly printed

throughout, and the paper is by no means first class. Judging by the authors' names much valuable information may be found in the volume; but it is too much to expect that any one who can afford to buy a book better printed will wear out his eyesight reading this one.

### LITERARY NOTES.

—Poultney Bigelow will contribute to the number of *Harper's Weekly* to be published February 19 an article on "The German Reichstag," with a picture of a scene during a session of the Reichstag, and with portraits of Barth, Bamberger, Richter, Prof. Virchow, Windhorst, and Stoecker.

### CORRESPONDENCE.

#### Cremation.

##### TO THE EDITOR.

*Sir:* There is not a valid argument against cremation. It is the correct method of disposing of the dead. Every statement made, viewing the question from its many standpoints, is in favor of it. To illustrate the strength of my belief: arrangements were made four years ago with Mr. V. Hard-ing, administrator of estate of Dr. F. Julius Le Moine, to have my own body cremated at Washington, Pa. This special permission was granted, because I was born there; received my degree of A. M. there; was a firm believer in the plan; and there also are buried ancestors for two generations, and a number of their descendants. That is where the body of Dr. Samuel D. Gross was cremated, May 8, 1884. Mark the growth of cremation! When Baron De Palm was cremated—the first orderly event of the kind in the United States—reporters flocked from the four corners of the Republic, and thousands came to look upon it, or to be near it; the leading dailies printed column after column descriptive of it; and it was a sensation hardly surpassed by the Cronin murder. The Baron was a Theosophist, known to but very few. Dr. Gross's name was a household word on two continents. Here is what the local paper said: "The body of Dr. Samuel D. Gross, one of the most eminent surgeons of the country, was brought to Washington on the 8th, and reduced to ashes in the Le Moine Crematory. He was 79 years of age." Four lines of brevier to note an occurrence which a half-dozen years before filled the press of the entire country.

People learn rapidly, and upon no subject more rapidly than upon cremation; they will, in another generation, practice what those living thoroughly believe. And grave-yards, expensive funerals and monuments, and all that, will be relegated to the dust of other barbarisms that have dissolved in the bright light of advancing civilization.

Yours truly,

J. M. SHAFFER, M. D.

Keokuk, Iowa,

Jan. 8, 1890.

### Puerperal Mastitis. Antipyrin and Antifebrin.

##### TO THE EDITOR.

*Sir:* In your editorial a few weeks back on "mastitis," you did not mention the treatment by pressure effected by means of a piece of rubber sheeting large enough to include the breast and thereby making equal pressure, by tying tapes to each corner and passing them around the body, one over the opposite shoulder to keep it in place and graduating the pressure by the tightness of the tapes in tying. A hole should be cut in the centre of the rubber, through which the nipple may pass. By this method all of the blood is driven from the breast and inflammation is prevented. I saw this a few years ago in the *REPORTER* and have tried it several times successfully. My neighboring physicians have also tried it and they say the results are highly satisfactory. The intense fever that accompanies this disease can be promptly controlled by free doses of jaborandi.

In regard to the comparative value of antipyrin and antifebrin in controlling the pain and fever of "*la grippe*," I have found antifebrin more satisfactory than antipyrin. The patients recover sooner, and it controls the pain and fever equally well. The thought has suggested itself to me that possibly the large death-rate in the cities from *la grippe* and its sequelæ may be due to the careless use of antipyrin. I am satisfied it is not a harmless drug, but should be cautiously used in depressing diseases, of which *grippe* is one.

Country doctors are, as a rule, less aggressive as regards heroic therapeutics than their city brethren. In a radius of many miles from here and a population of many thousands, I have not heard of a death from *la grippe* or its sequelæ. Antipyrin has

Feb. 1

been given satisfactorily a winter matter of interest to stances—costs \$1.

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Hatboro, Pa.  
Jan. 28,

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To THE EDITOR.  
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been given but little, and the results are satisfactory—in fact, I have not known of a winter so far with so few deaths. In the matter of cost—which is of material interest to those in poor, or moderate circumstances—antifebrin is much cheaper, costing twenty-five cents an ounce, while antipyrrin costs \$1.50 an ounce.

I have not tested antifebrin in dysmenorrhea, but am highly pleased with antipyrrin. To have a positive effect it is necessary to give it in fifteen-grain doses in severe cases. Repeat the dose in two hours if required. Keep your patient in a recumbent position for two hours after taking the drug. I have successfully treated, for the last few months, a woman who had had dilatation twice performed with only temporary relief, and removal of the ovaries was being seriously considered. Being called in to treat her in monthly attack I found her suffering intensely. Antipyrrin in fifteen-grain doses gave her complete relief and continues to give her relief every month since. I am satisfied I have saved the ovaries of several women already by the use of antipyrrin and hope to save many more in the future. The spaying of women is fashionable, but are not more women unsexed and rendered childless than are necessary?

Yours truly,  
JOHN B. CARRELL, M. D.

Hatboro, Pa.,  
Jan. 28, 1890.

### Antipyrrin and Antifebrin.

To THE EDITOR.

Sir: I have heard through the newspapers that there is a "dearth of antipyrrin on account of the extraordinary demand for use in the prevailing influenza." Now let us reason together. Antifebrin is worth with us forty cents per ounce; antipyrrin \$1.75 per ounce; the dose of the latter is fifteen to thirty grains, that of antifebrin five to ten grains. At the rate per dose the cost of antipyrrin to antifebrin would be as \$5.25 to forty cents. Now antipyrrin is a patented medicine, as far as name is concerned, and to is objectionable to the strict upholders of the "code of ethics."

As to antifebrin, no deaths have been reported from its use. It is used for the same indications as is antipyrrin. The dose is smaller, and any little too much has no unpleasant effects. The price is about one-

tenth that of antipyrrin. It is a better medicine for fever, because it has a tendency to promote perspiration. It is more sure in its effects as a remedy for neuralgic affections. It is not a patented medicine.

In writing the above I speak from a very considerable personal experience with both of them; and, aside from the price, I give preference to antifebrin for any use where either would be suitable.

Yours truly,  
BEN. H. BRODNAX, M. D.

Brodanax, La.,  
Jan. 24, 1890.

### Porro-Cæsarean Operation.—A Correction.

In the REPORTER of February 15, page 215, there is a typographical error in the letter from Dr. R. P. Harris, as follows: on line 11 of the second column, Dr. Heusner's operation is dated 1888; it should be 1880.

## NOTES AND COMMENTS.

### Atresia of the Vagina.

Dr. Thomas More Madden, of Dublin, has an interesting article on atresia of the vagina in the *Lancet*, Feb. 1, 1890, in which he says:

The subject of vaginal malformation or occlusion, as a cause of sterility and marital troubles, as well as of menstrual disorders, is one the practical importance of which is evident. Nevertheless, if in current medical literature be rightly reflected the prevailing tendencies of modern gynecological opinion, it would seem that whilst so much attention is devoted all to utero-ovarian and tubal affections, the study of abnormalities of that passage, on the integrity of which the due performance of woman's sexual functions essentially depends, is now somewhat unduly neglected. The following observations are therefore submitted, in the hope of inducing more adequate consideration of some of those abnormal conditions of the vagina which are of unquestionable interest from the special difficulties connected with their successful treatment.

In the first volume of the Transactions of the Academy of Medicine, may be found a short communication of mine on the subject of "Cicatrical Occlusion of the Vagina,"

and in a later volume I described certain other morbid conditions by which, whilst the structural integrity of this passage remains intact, its functional uses in relation to marital life and impregnation were impaired or destroyed. On the present occasion I purpose to consider that fortunately rare, but graver, congenital malformation that is occasionally presented in cases of entire or partial absence of the vagina, by which the patient is not merely incapacitated for marital life, but is also subjected to great physical suffering and danger. This subject was frequently referred to by the older writers: "One of the most remarkable instances of nature's wanderings from her accustomed laws," observed Dr. Davis, "is that which consists in the entire absence of the vagina. Cases of this defective formation are not numerous, but they are sufficiently numerous to establish the fact of their existence. Most frequently they are found combined with absence of the uterus, as also with that of one or more of its appendages." When in those cases there has been any passage at all, it but rarely exceeded an inch or an inch and a half in length, and has usually terminated in a cul-de-sac. Of this variety of defective development was the case of a porter's wife, related by Morgagni, in which the external parts of generation were very diminutive, and there was scarcely to be seen a trace of hymen. The entry into the vagina did not equal the dimensions of the middle finger in any direction; the breadth of the vagina when opened longitudinally and displayed was scarcely more than two fingers, and there were no rugæ on it. The parietes of the uterus were extremely thin, and the entire organ appeared not to have acquired any increment of bulk since the birth of its subject. There were no ovaries, a deficiency to which may reasonably be ascribed the imperfect development of the vagina and uterus.

Dr. Blundell, who in many instances, though not in this, was far in advance of the gynecological knowledge of his day, shared in the ancient doctrine as to the usual absence of uterus and general inadmissibility of any reparative treatment in these cases, and says: "When the closure above [of the vagina] is not partial, but reaches throughout the whole extent of the genital passage, the case scarcely admits of a remedy, nor, indeed, will the catamenia form." Many years later the same view was

supported by a surgeon to whom modern gynecology owes much of its development—viz., the late Dr. Marion Sims, who says: "I have seen five cases of congenital absence of the vagina, and in all of them there was no uterus." Dr. Macnaughton Jones observes: "If the vagina is congenitally absent, there is often no uterus as well."

Dr. Bousquet, of Marseilles, not long since recorded a case of this kind in the Gynecological Transactions, and in the recent American Cyclopaedia of Gynecology we find the old opinion on this point still sustained: "The whole canal may be absent, a condition which is commonly combined with absence of the uterus, but in other cases a normal uterus is found conjoined with the closed vagina."

The doctrine supported by all the authorities just cited would point to the general inadmissibility of reparative treatment in such cases. Fortunately, however, this often reiterated view is not correct as a general rule. Since the celebrated case reported more than fifty years ago by Amussat, of successful formation of artificial vagina, several others of the same kind have been from time to time reported in disproof of former views concerning the necessary connection between utero-ovarian and vaginal developmental lesions, and the impossibility of reparative treatment in the latter. Even yet, however, the number of such cases successfully treated is by no means very large, and hence it may be of interest to record here three additional cases, illustrating the treatment of congenital absence of the vagina. The most recent of these occurred a few weeks ago in my clinic in the Mater Misericordiae Hospital, where the patient was admitted under the care of the senior surgeon, Mr. Hayes, by whose kindness she was subsequently, on his examination and diagnosis of the nature of the case, transferred to my wards.

The subjoined notes are supplied by my clinical resident, Mr. T. G. Dillon, to whose unremitting attention the fortunate issue of the case is largely due.

*Case 1.* M. G., aged seventeen, a tenant farmer's daughter, living near Ballyhannon, county Roscommon, was admitted to hospital on Aug. 16, 1889. She had never menstruated, and complained of constant pain in her back for the past three years, and on palpation a swelling as large as the fetal head at full term before her admission had been discovered in the region of the

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uterus. This felt hard and movable, and was diagnosed to be a uterine tumor. At a certain period each month this swelling grew larger, and the pain in her back became more severe for a few days, when both gradually subsided. The mammae and external genital structures were well developed. On Nov. 3 a minute recto-abdominal examination of the case, under chloroform, was made by Dr. More Madden, to whose ward the case had been transferred, with the result that he discovered there was complete atresia vaginalis, from a quarter of an inch below the opening of the urethra. He decided on operating for the defect, which he did, assisted by Dr. Duke, on Nov. 7. The patient being placed in lithotomy position, a transverse incision was made through the vulval cul-de-sac, and thence continued upwards and backwards in what should have been the axis of the vagina by breaking through with the handle of a scalpel and point of the operator's finger the dense cellular interspace between the bladder and rectum, the position and integrity of which were carefully observed and guarded by the use of the sound in the former and the retention of his left index-finger in the latter. In this way a passage nearly six inches in length was cautiously made to the uterus. This being globular, and no trace of the cervix or os tincæ being apparent, an incision was then made with a bistoury into the most prominent and accessible part of the uterus, through which a catheter was passed into the cavity, giving exit to about forty ounces of dark-colored tarry blood, which on examination proved to be menstrual fluid; at the same time, the tumor in the abdomen began to grow smaller, and on pressing over the region of the uterus the discharge came away more quickly, which showed the tumor to be nothing else than a hemometra, or collection of retained menstrual fluid, which had been pent up in the uterine cavity. The uterus was then carefully washed out with an antiseptic solution, a drainage-tube was introduced into the uterus, and the new vagina plugged first with iodoform gauze, and subsequently with lint and cotton-wool soaked in glycerine of borax. The plug was removed and a fresh one put in twice daily, the uterus and vagina being douchèd at the same time through the drainage-tube, until the walls of the new vagina had healed over and the temperature fell to normal. On the day after operation her temperature rose to  $104^{\circ}$ , her pulse was

140, and, though there was no evidence of metro-peritonitis at any time, for some days her life hung in the balance, the symptoms pointing to septicemia. After the first week the main difficulty consisted in overcoming by repeated dilatation the great tendency to contraction of the new vagina. Ten days after operation a quantity of blood, similar in appearance to the catamenial discharge, was passed through the drainage-tube. The patient is now apparently quite well, and has a vaginal passage which easily admits two fingers. On Dec. 7 normal menstruation occurred.

For the particulars of the following interesting instance of congenital deficiency of the vagina I am indebted to my colleague, Mr. Coppinger, surgeon to the Mater Misericordiae Hospital, by whom it was successfully operated on.

*Case 2.* H. K., a thin, delicate-looking and poorly-developed girl of eighteen, was admitted under my care into the surgical ward of the Mater Misericordiae Hospital, May 10, 1889, complaining of pain in the back and of a tumor which was supposed to represent a psoas abscess. A superficial examination and inquiry into the history of the case sufficed, however, to prove that the tumor, which was about the size of an infant's head, and occupied the hypogastric and left lumbar regions was not an abscess, but a collection of retained menstrual secretion. An examination was now made under ether, when the fact that there was complete absence of the vaginal orifice, and apparently of the vagina, was elicited. On May 26 the patient was placed in the lithotomy position, and, with a finger introduced into the rectum and a metal male catheter, held by my house-surgeon, Dr. W. A. Morris, in the bladder, an incision was made in the middle line from about half an inch below the urethral orifice downwards for about an inch towards the anus. The recto-vesical septum was quite thin, and great care was necessary in order to avoid wounding the mucous membrane of the rectum on the one hand, or that of the bladder on the other. The two membranes were ultimately separated for about three inches before some loose areolar tissue was reached, and this was tunnelled with the finger until the abdominal tumor on its pelvic aspect could be felt. On pressing the latter from the front of the abdominal wall downwards, fluctuation could now be appreciated. Nothing resembling an os uteri could, however, be

discovered, so a trocar was thrust upwards in the middle line into the centre of the tumor. No fluid at first appeared, but, on passing a large aspirating canula along the same channel and pumping vigorously, some semi-fluid substance, jet black, and resembling tar in consistence and appearance, was evacuated. The canula was now removed, the opening widely dilated by means of my cervical dilator, and a quantity of weak, corrosive sublimate fluid passed into the cavity by means of an irrigator. In this way about a quart of tarry fluid was gradually evacuated, a drainage-tube was introduced through the new vaginal tube and new os into the cavity of the uterus, and the patient, after an operation which occupied more than an hour, sent back to her ward. There was no subsequent rise of temperature, but great difficulty was experienced in keeping open the new vaginal tube. With this object the patient was repeatedly etherized, drainage-tubes of various description being used. Indeed, but for the care and attention of my late house-surgeon, Dr. Morris, the operation would, I believe, have failed in its ultimate object. In the end, however, normal menstruation was established, and the girl left the hospital cured. I may mention that I heard from the country on December 17 that she was in good health.

Dr. Duke, gynecologist to Steeven's Hospital, has kindly furnished me with the notes of another case, under his care, also illustrating the successful treatment of this condition:

*Case 3.* M. C. was brought to me at the Rotunda Hospital by her mother, who informed me that she had never menstruated. As she was only seventeen years of age I adopted the usual routine treatment—hot baths, iron and aloes, etc.; but finding it of no use I made an examination, and could find no trace of the vagina; there was a dimple only where the orifice should be. The patient being poor, I had no assistance with the operation but her own mother, who, being a sensible woman, did as she was told. I administered ether, tied the patient up, and, having previously determined by the finger in the rectum and a sound in the bladder that a uterus existed, I worked my way with the finger and scalpel up to the cervix uteri, which was elongated and with the characteristic pinhole, as on making pressure over the uterus menstrual blood exuded, but only in small quantity; I

plugged the newly-made canal with wadding soaked in glycerine and carbolic acid, and after a few days inserted a glass plug. The patient menstruated naturally while the glass plug was being worn, so I removed it, and I heard the girl got good health, till I lost sight of her, as she went to some part of the country with her relatives.

#### Cure of Fistula in Ano without the Knife.

Dr. L. C. Pike, of Norway, Maine, writes in the *Massachusetts Med. Journal*, February, 1890:

A prompt and successful result, in several cases of anal fistula treated by injection of iodine, has induced me to call renewed attention to this subject. While disclaiming, of course, any originality for this *plan* of treatment, the *manner* in which I have employed it is perhaps somewhat new. At all events, it has thus far been entirely and permanently successful in my hands; and the suggestions of M. Henry, assistant to M. Bonnafont, as long ago as 1858, on this subject, seem to me to have met with undeserved neglect.

The iodine should be employed in the form of a *saturated ethereal* tincture. Its advantages over the officinal or alcoholic tincture are obvious. It is not only *stronger*, and thereby excites inflammatory adhesion in the walls of the tube, but the ether evaporates almost momentarily, and a pure coating of iodine is left along the fistulous track, which doubtless encourages absorption.

The instrument I have used is an ordinary hypodermic syringe, with small silver canula, which may be readily bent to correspond with the direction of the sinus, and the mode of operation is as follows: After exploring the fistula with a *very small* probe (the ordinary probe of the pocket-case is far too large), after determining its course and extent, the patient is to be placed in a good light and a glass rectal speculum introduced, with its fenestrum opposite the internal orifice of the fistula. The canula is now bent to the required curvature and introduced, when the syringe, filled with tepid water, is screwed on, and the surface thoroughly cleansed of all extraneous matter. This step is not only essential, but serves to allay timidity, or dread of the subsequent operation. Next, by pressure, the fistula in its whole extent should be dried out, and the

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## Notes and Comments.

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iodine will thus come in direct contact with its walls. Introduce now into the speculum a quantity of absorbent cotton. This will absorb any of the iodine which might otherwise be injected *through* and injure the mucous membrane, and by its characteristic stain will serve to show the completeness both of the fistula and of the operation. The canula may now be re-inserted and the injection made. It should be done *slowly*, and at the same time the canula gradually withdrawn. Every part of the surface will thereby be reached.

The operation, which is not very painful, should be premised with a cathartic and followed with a full anodyne, as ordinarily with the time-honored knife method. The patient need not be confined to his bed, or room, even for an hour.

Thus far I have performed this operation four times, and, as remarked above, with immediate and complete success. The patients were, all but one, below thirty years old. One was tuberculous, but no appreciable injury accrued from thus checking what we were once told is in phthisis a conservative drain. In my first case, a clerk, æt. 23, there was a dense and almost cartilaginous state of the fistulous wall, and the injection had to be repeated; but in the others one "sitting" alone was called for.

## Curious Vesical Calculus.

Dr. W. S. Elkin, of Atlanta, Ga., reports in the *Southern Medical Record*, February, 1890, the case of a boy 11 years old who, in last December, consulted him in reference to cystitis that had been troubling him for the last six years. He found him weak and anemic, presenting much physical evidence of long suffering.

On December 11, 1889, in presence of the class of the Southern Medical College and with the assistance of Drs. Gaston and Nicolson, the boy was anesthetized, six ounces of boracic acid solution injected into the bladder and an exploration made with Thompson's searcher. The presence of a stone was at once detected.

On December 14, the patient was again brought before the class, anesthetized, placed in the lithotomy position, six ounces of boracic acid fluid were injected into the bladder, and the stone was again recognized with the searcher. Dr. Elkin did the lateral operation, under strict antisepsis, and removed a

stone weighing 460 grains. On entering the bladder with the stone forceps, he came in contact with the calculus, which was presenting at the neck of the bladder just behind the prostate gland. It was easily grasped, but in endeavoring to extract it, although very gentle force was used, a part of it crushed and a portion about one-half inch in diameter, and an inch long, broke off from the nucleus and was removed. The forceps were again introduced and an attempt made to seize the remaining portion, which was wedged above and behind pubic bone and could not be reached until the operator had removed the instrument and introduced his finger and dislodged it from this position. It was then readily seized in its short diameter, and extracted. This fragment, which proved to be the nucleus, was about two inches long and an inch in diameter at its greatest thickness.

The calculus was of such peculiar shape that when the two fragments were put in their natural position it was found to be shaped like a boot. The short or horizontal portion presented at the orifice of the urethra and the long or vertical portion was behind and above the pubic bone. The inorganic element composing the calculus was phosphate of lime, which accounts for its interesting and peculiar shape, since it often happens that this special form of calculi conform themselves to the shape of the bladder.

For the first twenty-four hours after the operation, there was incontinence of urine. The temperature on the second and third days was  $102\frac{1}{2}^{\circ}$ . After this it became normal, the wound healed rapidly by granulation, and in less than three weeks after the operation, the patient was entirely well and had returned to his home in Alabama.

## Antiseptics, or Plain Water.

Dr. Chas. R. Illingsworth, of Accrington, writes, under date Dec. 10, 1889: "It seems to me that the best way to prove the superiority of antiseptics over water, in surgery, is to use the simplest form of dressing, with a penetrating solvent vehicle for the antiseptic agent. In this way only can the deeper tissues be thoroughly reached, and deep suppuration in all cases be thus avoided. There is no more potent combination of this nature than the solution of biniiodide of mercury in iodide of sodium. I have used

it in all kinds of wounds, abscesses and sores, and have found that it prevents suppuration, and ensures rapid union—by first intention in all possible cases—without the slightest irritation of the skin. I bathe recent wounds and amputation flaps once freely with the 1 in 1,000 solution, before bringing the edges together, but wash and dress afterwards with the 1 in 2,000 on ordinary lint once folded, and covered with gutta-percha tissue. I change the dressing every day for four or five days, and then less frequently, or dress with some antiseptic ointment. Dressed in this way with pure water, wounds would stink in two days, and suppurate in four." — *Dublin Journal of Med. Science*, February, 1890.

#### Tri-State Sanitary Association.

Arrangements have been completed to hold a Tri-State Sanitary Convention at Wheeling, W. Va., Feb. 27-28, 1890. Representatives will be present with papers and addresses from Pennsylvania, West Virginia and Ohio. The object of the Convention is to consider the question of floods and their results from a sanitary standpoint, and the best methods of managing the sanitary interests of a given community after such a calamity.

Owing to the relations held by these three States with reference to large rivers and the numerous towns in each one of these States that are annually affected by floods and their results, it has been thought wise to hold a convention for studying how best to manage the sanitary interests of cities and towns so affected.

Every person interested directly or indirectly in this important subject is earnestly requested to be present and assist in discussing the papers, and add whatever information he can to the solution of the practical questions.

Further information may be obtained by addressing the Secretary, Dr. George I. Garrison, Wheeling, W. Va.

#### National Conference of State Boards of Health.

It has been decided to hold the next Annual Conference of State Boards of Health at Louisville, Kentucky, about May 1st.

As heretofore, the Conference will be

principally devoted to the consideration of questions relating to the practical work of State Boards of Health, and in order that the discussions may be of the greatest value a list of the questions to be presented will be printed and sent to all State, Dominion, and Provincial Boards of Health.

All the Boards of Health are requested to send to Dr. C. O. Probst, Secretary of the Conference, at Columbus, Ohio, not later than March 1, 1890, one or more questions or propositions which they desire to have considered.

#### NEWS.

—It is proposed to establish a night medical service in London.

—Dr. Wharton Sinkler has removed to 1606 Walnut Street, Philadelphia.

—The sixth centennial of the foundation of the University of Montpellier, France, will be celebrated during May, 1890.

—A case of body-snatching has come to light in Knoxville, Tenn. The "subject" was found in the Tennessee Medical College.

—The Legislature of California has passed a bill appropriating \$80,000 for the erection of a new medical college for the University in San Francisco.

—A German hospital is to be erected in Brooklyn, and also one in Jamaica, Long Island. The managers of each have already elected themselves.

—Dr. Frank Ferguson, Pathologist to the New York Hospital, has been elected Professor of Pathology in the New York Post-Graduate Medical School and Hospital.

—A Bacteriological Institute of Preventive Medicine is to be established at the University of Cambridge. One of the principal lines of work will be anti-rabic inoculations.

—Several prominent physicians of New York City have joined in an appeal to the people of the State for the preservation of the Adirondack forests. These are gradually being destroyed through the introduction of small railroads in the interests of the lumber and iron industries.

—The treasurer of the tenth annual Charity Ball was authorized on Saturday to distribute \$2,150 each to the Sheltering Arms, the Philadelphia Polyclinic Hospital, the Visiting Nurse Society and the Philadelphia Lying-in Charity and Nurse School, being the proceeds of that ball.

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